**Maine Department of Health and Human Services**
# Application for Change of Administrator
**Adult Day Services Program**

PLEASE COMPLETE AND RETURN TO:

Division of Licensing and Regulatory Services
Community Services Programs
11 State House Station
Augusta, ME 04333

**For Agency Use Only**

**SBI** _____ **Prog. Spec.** _____

**1) This application form must be completed or the approval process could be delayed.**
**2) Return this application and related documents, and *one (1) additional copy* to the address above.**
**3) This application must be accompanied three (3) professional references.**
**4) A resume may be submitted in lieu of completing the sections on education, experience & employment.**
**5) This application must be accompanied with a check for the amount of $25.00 for a criminal background check. Make all checks payable to Treasurer State of Maine.**

## PROGRAM IDENTIFICATION:

Name of Adult Day Services Program: _____

Mailing Address of Program: _____
Street Address City State Zip

Physical Address: _____

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

## ADMINISTRATOR INFORMATION

_____
**(name)** First Middle Last

_____
**(home address)** Street Town State Zip Code

_____
Phone Number Date of Birth Social Security Number

*INDICATE OTHER NAMES KNOWN BY (MAIDEN NAME, ALIASES)* _____

## EDUCATION OF ADMINISTRATOR

| **School Name** | **City/State** | **Last Grade Completed** | **Degree** | **Year** |
|---|---|---|---|---|
| | | | | |
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## SPECIAL QUALIFICATIONS
## ENCLOSE COPY OF ALL PERTINENT CREDENTIALS

___ Multi- Level Administrator's License
___ Registered Professional Nurse
___ Certified Nurses Aide
___ Sign Language
___ CPR
___ Personal Support Specialist
___ Residential Care Administrator's License
___ Licensed Practical Nurse
___ Certified Residential Medication Aide
___ Other Language Spoken _____
___ Residential Care Specialist I certified
___ Direct Support Specialist

___ Other, explain: _____

**OTHER RELEVANT EXPERIENCE:** Describe previous paid, volunteer, or family experiences or training in working with elderly or disabled populations. (Use reverse side, if necessary)

The following questions are used to help evaluate the safety and security of consumers who will be served in the program. Issues in the following areas do not automatically mean a license will be denied.

Have you ever been convicted of a criminal offense? _____
If so, explain:

_____

_____

Have you (or the agency, if applicable) ever had a license for any long term care facility denied, suspended or revoked in this state or any other state? _____
If so, by whom? Please explain: _____

_____

Have you been investigated for child or adult abuse, neglect and/or exploitation? _____
If so, explain: _____

_____

Have you ever been treated for drug/alcohol abuse? _____
If so, explain: _____

_____

Have you ever been an inpatient in a mental health facility? _____
If so, explain: _____

**EMPLOYMENT HISTORY OF ADMINISTRATOR**

Give last 5 years employment history: (Attach separate sheet if necessary)

| **Name and Address of Employer** | **Job Responsibilities** | **Dates From:** | **To:** | **Reasons For Leaving** |
|---|---|---|---|---|
| | | | | |
| | | | | |

DATE OF HIRE OF NEW ADMINISTRATOR: _____

**The provider certifies that all information contained in this application is true and correct to the best of his/her knowledge.**

**The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for program administrator.**

**I, _____, being duly authorized to assume responsibility for the conduct of the assisted living facility herein described, do hereby certify that the above information is true and correct to the best of my knowledge. I/We understand that the signing of this application effectively serves as a release of information and gives permission to the Department to obtain any criminal history and Bureau of Motor Vehicle record which may be on file in any county or state office.**

**Signature of Provider: _____ Date: _____**

**Signature of Proposed ADMINISTRATOR: _____ Date: _____**

**REFERENCES** - INCLUDE THREE (3) WRITTEN PROFESSIONAL REFERENCES FOR THE PROPOSED PROGRAM ADMINISTRATOR FROM PERSONS WHO ARE NOT RELATED BY BLOOD OR MARRIAGE. THE QUESTIONNAIRE BELOW NEEDS TO BE COPIED AND GIVEN TO REFERENCES TO COMPLETE. REFERENCES MAY SUBMIT A LETTER, IF PREFERRED.

## PROFESSIONAL REFERENCE FOR ADULT DAY SERVICES PROGRAM ADMINISTRATOR

**Referent's Name**: _____ **Name of Proposed Administrator**: _____

**Adult Day Services Program Name**: _____

**Please respond to the questions below. Use the back of this sheet if necessary.**

1. How long have you known the applicant?

2. In what capacity do you know this person?

3. Are you familiar with this person's professional experiences in serving persons who are elderly or disabled? If yes, please describe.

4. Please comment on the following areas:

   A. Knowledge about elderly and disabled persons.

   B. Capacity to supervise staff, demonstrate leadership.

   C. Fiscal management of program operations.

   D. Ability to work with outside resources such as financial agencies, state agencies, medical professionals, social workers, friends and families of consumers, etc..

   E. Outstanding contributions to the field related to the provision of assisted living services.

6. Do you have any concerns about this person's ability to work in a management capacity in a Adult Day Services Program?

7. Do you recommend that this person be given the opportunity to work in or operate an Adult Day Services Program?